



John Elias Baldacci
Governor

STATE OF MAINE
DEPARTMENT OF HEALTH & HUMAN SERVICES
BUREAU OF ELDER AND ADULT SERVICES
442 CIVIC CENTER DRIVE
11 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0011

John R. Nicholas
Commissioner

MaineCare Home Health Referral Attachment (Age 21 and over)

Member: _____

MaineCare #: ☐☐☐☐☐☐☐☐☐☐

Section 40.02-3

- ☐ Attached is the Form HCFA-485 Plan of Care signed by the member's physician. The member's physician signed and certified a plan of care that safely and appropriately treats the member's medical condition. **OR**
- ☐ Attached are physician orders for the plan of care at time of discharge. The member is located in a hospital.

AND

- ☐ These services are not available and safely accessible to the member on an outpatient basis.
- ☐ Medically contraindicated with likelihood of a bad result.

Specify reason: _____

_____. **AND**

- ☐ The member's condition requires skilled nursing care on a "part-time" or "intermittent" basis, or physical, occupational, or speech therapy as defined in Section 40.02-3 (E).

Prior Authorization required: Check the category of service that you are requesting Goold Health Systems to prior authorize for this member.

- ☐ Member requires additional certification period for unstable medical condition for continued assessment and management of skilled services as defined in Section 40.06-E.

Start of Care Date: ____/____/____

- ☐ Member requires continued home health services.
- ☐ Member appears to be Nursing Facility level of care.
- ☐ Prior Authorization is needed to add additional services to Section 17 plan of care.

Person completing this form: _____

Date: _____

Provider Name: _____

HH Referral-BEAS 7_1_04